Health Services
LOS ANGELES COUNTY

Mitchell H. Katz, M.D.
Director

Los Angeles County Department of Health Services

Policy & Procedure Title:	Principles and Guidelines for Assisting Uninsured Patients
Category: 500-599 Fiscal & Budget Policy	Policy No.: 515.01
Originally Issued: *02/01/2006*	Update (U)/Revised (R): 01/01/2015 (R)
OHS Division/Unit of Origin: Finance	
Policy Contact – Employee Name, Title and DHS Division: Arthur Bernal, Chief, Revenue Services	
Contact Phone Number(s):	(213) 240-7985
Distribution: DHS-wide IXI	If not DHS-wide, other distribution:

PURPOSE:

To adopt principles and guidelines to meet the financial needs of uninsured and underinsured patients receiving services in DHS' facilities.

POLICY:

The Department of Health Services (DHS) will maintain reduced-cost health care programs for patients who have limited or no financial resources to pay for the medical services received at DHS' facilities.

DHS shall maintain written financial assistance policies for low-income uninsured patients that address both the charity care and discount programs known as "reduced-cost health care plans (RCHCP)". Examples of these RCHCPs include Ability-To-Pay (ATP) and Discount Payment Plan (DPP), both of which are considered the DHS plans for purposes of meeting Health & Safety Code § 127405 requirements, and Pre-Payment.

The ATP financial practice policy shall cover both free and reduced-cost services, for Los Angeles County residents, based on income level. Persons eligible for ATP with income at or below 138% of the federal poverty level (FPL) shall have no liability for the costs of their care and persons eligible for ATP whose income is above 138% FPL shall receive care at a reduced cost.

All uninsured Los Angeles County residents are eligible to apply for ATP. All Out-Of-County/Out-Of-Country/Foreign Visitors and Non Immigrant Persons treated at a Los Angeles County (County) hospital whose family income is less than or equal to 350% of the FPL are eligible to apply for the DPP. The ATP financial practice policy and DPP policy will set forth

Revision/Review Dates:
Department Head/Designee Approval:

the eligibility criteria for reduced-cost or free care. The ATP and DPP policies together shall ensure that all uninsured or underinsured persons (including those with high medical costs) whose family income is at or below 350% FPL shall be eligible for some form of reduced-cost program for services at a County hospital. Under both ATP and DPP, the liability of a patient whose family income is at or below 350% FPL will be the lesser of the calculated liability, or the amount Medi-Cal would pay for the same service. However, if the amount the Medi-Cal program pays for the service exceeds the facility's charges, the patient liability shall be reduced to 95% of total charges.

Reduced-cost care is also available under ATP to some persons whose income is above 350% FPL.

Facilities will evaluate the patient's eligibility for financial assistance for government sponsored programs, including the Health Benefits Exchange.

Notices regarding the availability of financial assistance to low-income and uninsured patients must be posted in visible locations throughout each County hospital including at least Admitting/Registration, Billing Inquiry, Emergency Department and other outpatient settings.

Every posted notice regarding financial assistance policies must contain brief instructions on how to apply for assistance under the RCHCP: The notices must also include a telephone number that can be used to obtain additional information.

DHS shall provide patients with a written notice that contains information about availability of the hospital's ATP and DPP programs, including summary information about eligibility, as well as contact information for a facility employee or office from which the person may obtain further information about these programs.

Facilities shall provide Medi-Cal applications to all patients who either indicate no third-party coverage or apply for ATP or DPP as persons with high medical costs before discharge or departure from the hospital.

Facilities must ensure that appropriate staff members are knowledgeable about the existence of DHS' RCHCP. Training on these programs will be provided to staff members who directly interact with patients regarding their medical bills (e.g., billing inquiry office, financial department, etc.).

Facilities must ensure RCHCP are applied consistently.

Facilities should communicate information to the patient regarding financial assistance policies in the primary language of the patient or his/her family, if reasonably possible, and in a manner consistent with all applicable federal and state laws and regulations, as well as County policy.

DHS will share their financial assistance policies with appropriate community health and human services agencies and other organizations that assist such patients.

DHS will ensure that contracted vendors are knowledgeable about the DHS financial assistance policies and aware of their obligation to make the RCHCP available to qualified patients.

DHS shall make available an extended payment plan which is interest free to persons with a financial liability (see Financial Practice (FP) 520.27).

DHS will have written policies regarding when and under whose authority patient debt is advanced for collection. DHS will use its best efforts to ensure that patient accounts are processed fairly and consistently (see FP 530.08 – Referral of Delinquent Inpatient Self-Pay Accounts to Outside Collection Agencies and FP 530.14 – Referral of Delinquent Outpatient Self-Pay Accounts to Outside Collection Agencies).

DHS will have policies on the standards and practices for the collection of debt and shall require all contracted collection agencies to comply with those policies.

DHS may obtain and retain the written policies from contracted Collection Agency Vendor regarding collection practices to ensure compliance with County policies. DHS shall require contracted billing agents and contracted collection agencies to provide all legally required notices to patients, and to comply with the County's definition and application of a reasonable payment plan.

GUIDELINES:

It is the responsibility of any patient seeking financial assistance from the facility (or the patient's legal representative) to provide the facility with information concerning health benefits coverage, financial status and any other information that is necessary for the facility to make a determination regarding the patient's eligibility under any RCHCP or government-sponsored programs and the amount of his or her liability under the RCHCP. The DHS facility will inquire of every patient regarding the existence of any possible applicable health care coverage.

DHS' RCHCP financial practices must allow a reasonable period for the patient to submit the information necessary to determine eligibility.

At the time of billing, facilities and outside vendors shall provide to all low-income uninsured patients at least the same information concerning services and charges as is provided to all others in the same financial class. Bills to uninsured patients shall include all legally required information, including information about possible eligibility for government sponsored programs and about applying for government sponsored programs including coverage from the California Health Benefit Exchange (Covered California) or RCHCP. Note: DHS facilities do not itemize bills. A series of bills (data mailers) are sent to the patient. Each of the bills in the series has a slightly different message.

The facility or outside collection agency operating on behalf of the County shall not, in dealing with low-income or uninsured patients, use wage garnishments (or in most circumstances, sale of the patient's primary residence) as a means of collecting unpaid bills. This requirement

does not preclude facilities or its contracted agency from pursuing reimbursement from third-party liability settlements, tortfeasors, or other legally responsible parties.

REFERENCE(S)/AUTHORITY:

DHS Policy Nos.:

318 Non-English and Limited English Proficiency
515 Registration/Financial Screening516 Non-Emergency Medical Care Services Requirements - Los Angeles County Patients
516.1 Non-Emergency Medical Care Services Requirements – Out-of-County and Out-of-Country/Foreign Visitor and Non-Immigrant Persons
520 Charging and Collecting Requirements for Medical Care Services Rendered530 Collections

Financial Practice Policy Nos.:

515.01 Inpatient Admission and Discharge Procedures Related to Patient Financial Screening
520.15 Ability-To-Pay Plan Verification Guidelines

520.26 Pre-Payment Plan

520.27 Extended Payment Plan

520.28 Discount Payment Plan (DPP) Guidelines

530.08 Referral of Delinquent Inpatient Self-Pay Accounts to Outside Collection Agencies

530.14 Referral of Delinquent Outpatient Self-Pay Accounts to Outside Collection Agencies

California HealthCare Association - Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patients

Etter Consent Decree Flyer – You Can Get No-Cost or Low-Cost Medical Care at Any LA County Clinic or Hospital, 4/14

Financial Practice

Department of Health Services

RELEASE No.	520.15
RELEASED	February 5, 1985
EFFECTIVE	February 5, 1985
REVISED	January 1, 2015

ABILITY-TO-PAY VERIFICATION GUIDELINES

PURPOSE: To establish uniform guidelines for implementing the Ability-To-Pay Plan (ATP).

GENERAL: ATP requires, as a condition of eligibility, certain information disclosed in connection with the ATP Services Agreement to be confirmed, upon request by the County.

For Los Angeles County residents, ATP serves as one of the hospital's Charity Care and Discount Payment Plans for purposes of Health & Safety Code §127405.

ATP Services Agreements are processed at all DHS facilities.

DEFINITION: Verification means the act of obtaining evidence which either confirms or invalidates the facts asserted by the patient and/or patient's responsible relative(s).

Clarification means the act of obtaining additional information in order to resolve unclear or inconsistent statements made in connection with the ATP Services Agreement.

Documenting means to attach supporting evidence to the ATP Services Agreement. To the extent possible, acceptable documentation consists of the original or a photocopy of the verifying information.

Patient's Family means: (1) for patients 18 years of age and older: spouse, (including same sex) domestic partner (i.e., same sex partners who are legally registered with the State), and dependent children under 21 years of age, whether living at home or not, or (2) for patients under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

RELEASE NO. 520.15

RELEASED February 5, 1985

EFFECTIVE February 5, 1985

REVISED January 1, 2015

RESPONSIBILITY: The Facility Finance Directors shall be responsible for the implementation of, and compliance with, this Practice.

PROCEDURES: See detailed procedures attached.

NOTED AND APPROVED:

Allan Wecker
Chief Financial Officer
Subject to Revision 1st quarter 2015

RELEASE NO. 520.15

RELEASED February 5, 1985

EFFECTIVE February 5, 1985

REVISED January 1, 2015

PROCEDURES

SUBJECT: Ability-To-Pay Plan (ATP) Verification Guidelines.

SCOPE: These procedures include the actions to be taken by the financial staff of each facility to verify ATP.

PROCESSING MATERIALS:

Exhibit I	Medi-Cal Linkage Checklist
Exhibit II	Medi-Cal Referral Form
Exhibit III	ATP Services Agreement
Exhibit IV	ATP Verification Guidelines
Exhibit V	ABCDM 228 - Applicant's Authorization For Release of Information

RELEASE NO. 520.15

RELEASED February 5, 1985

EFFECTIVE February 5, 1985

REVISED January 1, 2015

RESPONSIBILITY	ACTION REQUIRED
Patient Financial Services/Eligibility Staff	I. Per existing procedures, financially screen and refer the patient for an ATP interview, as appropriate.
	II. Begin ATP interview.
	III. Advise the patient that ATP covers all inpatient or outpatient medical care services provided at Los Angeles County Department of Health Services (DHS) facilities for qualified individuals. Note: Inpatient and outpatient services are covered by the same application, but have separate liability amounts that must be determined.
	IV. Verify the patient's and/or patient's responsible relative(s) permanent address (see Financial Practice 515.11).
	V. Verify the patient's and/or patient's responsible relative(s) identity (see Financial Practice 370.11)
	VI. Complete Medi-Cal Linkage Checklist (Exhibit I) and utilizing the Medi-Cal Referral Form (Exhibit II), refer eligible patients to apply for Medi-Cal if potential eligibility exists. Refer patients to the California Health Benefits Exchange (Covered CA), if they appear eligible. Note: If the patient is eligible to the Medi-Cal program, they must apply and cooperate with the Medi-Cal application process before being eligible to apply for ATP. However, process the patient for eligibility in the discount payment plan (DPP) (Financial Practice 520.28) during the pendency of the Medi-Cal application. If the patient refuses to cooperate with the Medi-Cal

RELEASE NO. 520.15

RELEASED February 5, 1985

EFFECTIVE February 5, 1985

REVISED January 1, 2015

RESPONSIBILITY	ACTION REQUIRED
Patient Financial Services/Eligibility Staff	application process, notify the patient that his/her ATP application is denied. Inform the patient that he/she can apply for the discount payment plan, and then follow the steps at XIX below (Page 6).

VII. Complete the ATP Services Agreement (Exhibit III) based on information provided by the patient and/or patient's responsible relative(s).

VIII. Determine those ATP Services Agreement information items to be verified, e.g., Social Security Number (SSN) in accordance with Exhibit IV.

IX. Request verification for ATP Services Agreement information items, as required in Exhibit IV, from the patient and/or the patient's responsible relative(s).

X. Explain to the patient and/or the patient's responsible relative(s) acceptable methods of ATP verification.

XI. Allow the patient and/or the patient's responsible relative(s) up to a maximum of 30 calendar days from the date of the original request to provide ATP verification.

XII. Deny the ATP application, if verification is not provided within 30 calendar days from the date of the original request, or

XIII. Complete the ATP Services Agreement, if verification is provided.

XIV. Review ATP Services Agreement with patien/responsible relative(s) to confirm his/her understanding of the agreement.

XV. Inform the patient that for the time period covered by the ATP Agreement, he/she must report any changes in his/her financial circumstances, or family size as these

RELEASE NO. 520.15

RELEASED February 5, 1985

EFFECTIVE February 5, 1985

REVISED January 1, 2015

factors could impact their ATP liability.

RESPONSIBILITY		ACTION REQUIRED
Patient Financial Services/Eligibility Staff	XVI	Inform the patient that if, during the ATP eligibility period, it is determined that the patient is eligible for coverage by a tortfeasor or his/her insurance, the ATP Services Agreement will be null and void as of the effective date of eligibility. However, if the patient becomes eligible for Medi-Cal with no share-of-cost (SOC), the scope of ATP shall be limited to services which are not covered by Medi-Cal. If the patient becomes eligible for Medi-Cal with a SOC, the patient must reapply for ATP, which will be limited to services which are not covered by Medi-Cal. Patients who qualify as high medical cost, as defined in the Health and Safety Code 127400 may apply for the DPP (Financial Practice 520.28) for assistance with services covered by Medi-Cal. If the patient becomes eligible for other types of health care coverage, the patient must reapply for ATP, which will be limited to the patient responsible amounts and non-covered services.
	XVII.	Approve the ATP Services Agreement, if the patient and/or the patient's responsible relative(s) have met all eligibility requirements.
	XVIII.	Update the Health Information System (HIS) with appropriate standardized carrier code(s).
	XIX.	If patient is found not to be eligible, inform patient of his/her right to seek review of the decision within 10 working days and provide information on how to request review.
	XX.	Explain effective dates (from/through) for the ATP Services Agreement to the patient. Note: The ATP Agreement is effective for one (1) year for both inpatient and outpatient services.

RELEASE NO. 520.15

RELEASED February 5, 1985

EFFECTIVE February 5, 1985

REVISED January 1, 2015

XXI. Update the HIS with the ATP Agreement effective dates.

XXII. If applicable, explain the ATP liability amount to the patient. Patient liability is generally the lowest of the ATP liability amount, the amount Medi-Cal would reimburse for services or 95% of the actual charge. If the patient is eligible for ATP, the patient's ATP liability amount shall not be greater than the amount the facility would receive from the Medi-Cal program for the same services to a Medi-Cal eligible patient. In determining which is higher, compare the patient's outpatient liability for the month or the admission with Medi-Cal payments for all services within the month or admission and the actual charge for all services during the month or the admission. Do not do the comparison on a service by service basis. If the amount the facility would receive from the Medi-Cal program exceeds charges, the patient's liability amount shall be no greater than 95% of total charges for the month/admission.

XXIII. Inform the applicant that if they dispute their ATP liability amount determination, they may request a review at the supervisory level within 10 working days.

XXIV. Inform the patient that he/she has the option to make payment for his/her liability via an Extended Payment Plan agreement. The Extended Payment Plan agreement will allow the patient to make payment of his/her ATP liability over time. See Financial Practice 520.27 – Extended Payment Plan rules.

XXV. Provide a copy of the ATP Services Agreement to the patient and maintain a copy in file.

XXVI. If the patient or the patient's authorized representative claims that his/her Medi-Cal application has been denied, but the denial is being appealed, and he/she makes a reasonable effort to inform the hospital about the progress of a pending Medi-Cal appeal, the hospital facility should not refer the patient's liability to collection unless a final negative determination of that appeal is made.

RELEASE NO. 520.15

RELEASED February 5, 1985

EFFECTIVE February 5, 1985

REVISED January 1, 2015

XXVII. If the patient previously paid the hospital in excess of the amount due, the hospital shall reimburse the excess of the amount due including interest at a rate of 10% per annum, starting on the date that the payment from the patient was received.

When restricted Medi-Cal has been determined refer to PFS Memo 45-04.

Failure of the patient to provide information required for the hospital to make a determination for the ATP Plan will result in a denial of the application.

However, if the patient subsequently provides all of the required information, eligibility for ATP will be determined.

CROSS REFERENCE: Extended Payment Plan, Financial Practice 520.27

Patient Address Verification, Financial Practice 515.11

Patient Identity Verification, Financial Practice 370.11

Health & Safety Code §127400 and subsequent.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

MEDI-CAL LINKAGE CHECKLIST

Date Completed:_____ Patient:_____ MRUN #: ____

Financial Screener:_____ Facility:_____ Admission/Outpatient Date:____

Hospital Presumptive Eligibility (HPE)

(If "Yes" is answered to any question below, HPE Medi-Cal linkage exists. Refer patient to PRW/PFSW)

Evaluate if potentially eligible for HPE benefits (Hospital Inpatient and Outpatient*), is patient:

a) Between age 19-26 and in foster care on the month of their 18th birthday? Yes D No D
b) A Child (ages 0-18) at or below 266% of the Federal Poverty Level (FPL)? Yes D No D
c) A Parent, caretaker relative or a "new adult" (ages 19-64) at or below 138% FPL? Yes D No D
d) A pregnant woman at or below 213% FPL (outpatient prenatal and pregnancy related services only)? Yes D No D

NOTE: To be eligible under the above categories, individuals must be uninsured California residents (i.e., no coverage such as private insurance, Medicare, Medi-Cal, etc.). To be eligible in the first three categories, the individual must not be pregnant.

* Inpatient and Hospital based Outpatient only.

Eligibility Screening:

If "Yes" is answered to any question below STOP Medi-Cal linkage exists. If linkage exists, refer patient to PFSW, on-site Eligibility Worker, or DPSS office for Medi-Cal.

A. EVALUATION STEP

1. Is patient age 19 or older and under age 65,
   AND
   Does patient have a household income at or below 138 percent of the Federal Poverty Level for the applicable family size?
   Number in Household Gross Income $ Yes o No o
2. Is patient 65 years of age or over? Yes o No o
3. Is patient under 21 years of age? Yes o No o
4. Is patient pregnant? Yes o No o
5. Is patient a caretaker relative of children, (e.g., grandchildren, niece/nephew, cousin, brother/sister) in the home under 21? Yes D No D
6. Is patient a stepparent? Yes o No o
   "Stepparent may be eligible if parent of separate child(ren) is in the home."
7. Is patient blind (i.e., visual acuity 20/200 with correction or tunnel vision)? Yes D No D
8. Is patient disabled, (i.e., has a physical/mental condition which prevents him/her from working for at least a year or will result in death)? [If patient is receiving *Social Security/Railroad Retirement Disability Benefits,* he/she is disabled.] Yes D No D
9. Is patient residing in a Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF)? Yes o No o
   (Note: This category only covers SNF/ICF and outpatient care.)

If "Yes" is answered to at least one of the above questions, Medi-Cal linkage exists.

If linkage exists, refer patient to PFSW, on-site Eligibility Worker, or DPSS for Medi-Cal application. Attach Medi-Cal Linkage Checklist to Medi-Cal Referral Form.

Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Deputy Director, Strategy and Operations

313 N. Figueroa Street, Suite 518
Los Angeles, CA 90012

Tel: (213) 240-8277
Fax: (213) 240-8028

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at D H S facilities and through collaboration with community and university partners.

Date: _____

TO: Department of Public Social Services/Patient Financial Services

FROM: _____ _____
(Worker's Name) (Facility)

SUBJECT: **REFERRAL FOR MEDI-CAL APPLICATION**

Patient's Name _ Date of Birth _____
MRUN # _____

We are referring the above person to apply for Medi-Cal. He/she appears to meet the Medi-Cal eligibility requirements. (Refer to attached Medi-Cal Linkage Checklist.) The patient is currently receiving health care services from our Department.

Mr. /Mrs. has applied for Ability-To-Pay (ATP). However, as a condition of eligibility to this program, the patient must apply for Medi-Cal, if potentially eligible, and must fully cooperate in the eligibility determination process, regardless of the level of benefits to which he/she may qualify, (i.e., either full or restricted). In order to proceed with ATP, Medi-Cal must be denied for reasons other than failure to cooperate or patient must be approved for restricted benefits only. The patient identified above would be eligible for benefits under the Discount Payment Program during the pendency of a Medi-Cal application or if he/she does not cooperate with the Medi-Cal process; however, we would encourage you to help the patient understand the value of the Medi-Cal benefits before he/she makes a decision not to cooperate.

Thank you for your cooperation in this matter. If you have any questions or need additional information, please call me at ( )_____

Attachment:

DPSS/PFS:
If an application is not taken for patient, please indicate reason for ineligibility and return form to patient.

_____
_____
_____

Worker's Name _____
Telephone No. ( ) _____

Exhibit III

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
ABILITY-TO-PAY (ATP) PLAN SERVICES AGREEMENT

Facility: _____ MRUN# _____ Date: _____

SECTION I: PATIENT INFORMATION

Patient: _____ DOB: _____ Social Security #: _____

Address: City: State: Zip: _____

Telephone: [Home] , ,_____ Work] , ,_____ [Message] _____

Los Angeles County Resident D Yes D No (Ineligible) Patient has approved Restricted Medi-Cal D Yes D No

SECTION II: INCOME INFORMATION

Family members in patient's household_____ Total Monthly Income _____
(From Worksheet Part B, Line 1)

SECTION III: ATP LIABILITY

In consideration for being charged for health care services rendered by the County of Los Angeles (County) to the patient in accordance with the County's Ability-to-Pay Plan (ATP), I/we (patient or responsible relative) _____" promise to pay the County for services received from the County's health care facilities, from through , the ATP Liability Amount of:

_____dollars ($ per admission for all inpatient services provided to the patient covered by this Agreement from admission until discharge from the County's Health care facility;
AND
_____dollars ($ for each month during which outpatient services are received by the patient covered by this Agreement for all outpatient visits provided during that month.

SECTION IV: ATP CERTIFICATION

Such ATP Liability Amount has been determined under the ATP and is based upon information which I/we provide in this Agreement. I/we understand that I/we may be asked later for proof of some or all of the information used for this Agreement. I understand that I am expected to save documents I might have that would help prove that what I said today is true, (for example, copies of pay stubs, income tax returns, bank statements, receipts), for 6 months from the date of the application. If I am asked for these documents in the next 6 months, I will have 20 days to mail or bring the information to the facility or to give some other acceptable verification. If I am asked for this proof and don't provide it, I may be held responsible for the full charges for my medical care.

It is understood and agreed that the above ATP Liability Amount for such inpatient services or for such outpatient services shall not be subsequently adjusted for any reason except as provided under the ATP.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the ATP, which has been made available to me/us for review and which is incorporated herein by reference, and that I/we shall fully cooperate with the County in accordance with the ATP. Pursuant to Section 360.5 of the California Code of Civil Procedure, I/we agree that all statutes of limitation upon the debt for the health care services which are covered by the Agreement are hereby waived.

I/we certify that, during the next year, if the patient gets or loses insurance, or if his or her family size or income changes, I/we promise to immediately report that fact to the facility where this form was completed.

It is agreed that if I/we have a change in financial circumstances, including but not limited to an increase in the patient's or guarantor's income, or the patient, or patient's heirs or personal representative(s), receipt of damages recovered as a result of patient's injury by accident, negligence, or wrongful act, I/we will notify the facility where this Agreement was completed and this Agreement may, at the election of the County of Los Angeles, be terminated, and the County's hospital shall be entitled to its reasonable charges.

This agreement shall not in any way diminish or defeat the County's right, under the California Government Code sections 23004.1 and 23004.2, or the Hospital Lien Act, or any other applicable laws to recover reimbursement from any responsible third-parties, including tortfeasors, the reasonable charges for health care services provided to the patient.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
ABILITY-TO-PAY (ATP) PLAN SERVICES AGREEMENT

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE PROVIDED AS PART OF THE APPLICATION PROCESS AND AS LISTED ABOVE IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY BY MY/OUR SIGNATURES THAT I/WE HAVE READ AND UNDERSTAND ALL THE FORGOING AND THAT I/WE AGREE TO SIGN THIS STATEMENT WITHOUT ANY RESERVATION WHATSOEVER.

Signature	Date	Responsible Relative Signature	Date
Interviewer Signature	Date	Responsible Relative Signature	Date
		Supervisor's Approval	Date

EXHIBIT IV

VERIFICATION GUIDELINES FOR ABILITY-TO-PAY PLAN (ATP)

GENERAL:

Before eligibility for Ability-To-Pay Plan (ATP) can be established, certain information must be disclosed by the patient/responsible relative(s) in connection with the ATP Services Agreement.

In order to be eligible for ATP, a patient must be a Los Angeles County resident, must apply and cooperate with the Medi-Cal application process if linked to the program, and must have charges which Medi-Cal, Medicare, private insurance or other medical benefits won't cover. While an application for coverage under another program is pending, the patient is not eligible for ATP, but maybe eligible for the Discount Payment Plan (DPP) (Financial Practice 520.28). If application for coverage under another program is denied for reasons other than non-cooperation, the patient may be retroactively eligible for ATP for services provided before and during the Medi-Cal application period.

Note: Verification of income by declaration is required in order to finalize the ATP application. Additionally, when such information is unclear or in conflict, additional clarification must be requested and the clarifying information recorded.

DEFINITIONS:

Verification means the act of obtaining evidence, which either confirms or invalidates the facts asserted by the patient and/or patient's responsible relative(s).

Clarification means the act of obtaining additional information in order to resolve unclear or inconsistent statements made in connection with the ATP Services Agreement.

Note: In some situations, clarification and verification may be the same. A document, which could provide clarification, may also be acceptable as verification, if verification were required.

Documenting means to attach supporting evidence to the ATP Services Agreement. To the extent possible, acceptable documentation consists of the original or a photocopy of the verifying information.

When an entry is to be made in lieu of attaching evidence, that entry must include:

- The reason why the document was viewed rather than attached,
- The type and date of document viewed,
- All pertinent information from the document including identifying data and specific facts which support the statements to be verified,
- The date the document was viewed, and
- The interviewer's initials.

Legally responsible relative means "responsible relative" as defined in California Code of Regulations, Title 22, Section 50351.

RESPONSIBILITY FOR VERIFICATION/CLARIFICATION

The applicant and/or responsible relative(s) has the primary responsibility for providing any required verification or clarification. Primary responsibility means that the applicant/responsible relative(s) must obtain and provide requested information or evidence necessary to verify or clarify the required items on the ATP Services Agreement.

Note: Applicant is to be informed of alternative methods for verification, if necessary.

When the applicant/responsible relative(s) is cooperative, but through no fault of his/her own has been unable to obtain the evidence needed, the interviewer may initiate a request for verification directly to an outside person/organization which would have the information. A completed ABCDM 228, Applicant's Authorization for Release of Information (Exhibit V), or facsimile or PDF file of that form, signed by the applicant/responsible relative(s) must be attached to each request for verification made to a person/organization other than the applicant/responsible relative(s).

If, after initiating the ABCDM 228 along with a request for information, the interviewer is still unable to obtain needed information, an Affidavit may be used as documentation as a last resort except for income. For income, an Affidavit is considered the primary source for verification, as discussed below.

When the applicant/responsible relative(s) is cooperative with the verification process, but through no fault of his/her own has been unable to obtain or provide the evidence needed, the interviewer may:

- Document all actions taken to obtain evidence required for verification, and
- Secure from the applicant/responsible relative(s) an Affidavit dated and signed under penalty of perjury which lists and describes the evidence in the same detail as would be required of acceptable verification.

ITEMS REQUIRING VERIFICATION/CLARIFICATION/DOCUMENTATION

A. Social Security Number

The Social Security Number (SSN) should be verified, <u>whenever possible</u>.

Note: Inability of the applicant to provide evidence of a SSN does <u>not</u> constitute a basis for ineligibility for ATP.

Verification includes, but is not limited to:

1. Social Security card,
2. Award letter (e.g., Social Security Administration, Disability Insurance Benefits, etc.),

3. Medicare card,

4. Check from Social Security Administration (SSA) which shows the applicant's name and SSN with the suffix A, HA, J, T, or M,

5. Correspondence from SSA,

6. Paycheck stubs and/or company ID badge/card which specify both the applicant's name and SSN, and

7. Medi-Cal Eligibility Data System (MEDS) with a Social Security "J" verifier.

Documentation for the ATP Services Agreement should include the original, a photocopy of the evidence, or description of how the SSN was verified.

If the applicant does not have an SSN, he/she should be encouraged to apply for one. The lack of an SSN should be documented on the ATP Services Agreement. Further, the interviewer should inform the applicant to retain, for future reference, any correspondence from SSA related to applying for an SSN.

SSN verification is not required from other family members. However, if SSN verification is available, the interviewer should document that verification on the ATP Services Agreement. If any family member does not have an SSN, he/she should be encouraged to apply for one and retain any correspondence from SSA.

B. Address

Los Angeles County residency is required for ATP eligibility. Therefore, current address verification <u>is required</u>. The patient's current address is to be verified if it is not the same address used when the patient received services. If the patient's current address is the same address used when the patient received services, and the address has already been verified, additional verification is not required. The following documents are acceptable examples of current address verification, in order of preference:

1. Valid California Driver's License,

2. Valid Department of Motor Vehicles (DMV) Identification Card,

   Note: Short term DMV Identification Card that expires when foreign visitor documentation expires is <u>not</u> acceptable for purposes of address verification.

3. Government issued identification card with the patient's or legally responsible relative's picture and address (e.g., Matricula Consular, etc.),

4. School Identification,

5. General Relief Identification (EBT Card),

6. Utility Bill,

7. Any mailing addressed to patient/responsible relative(s) and cancelled by the U.S. Post Office, and

8. Rent receipt or letter from provider verifying in-kind residential address.

Note: For 6, 7, and 8, above, documentation dated within 60 days of the date presented shall be considered current.

Case file should reflect how the address was verified, and this information should be recorded in the Health Information System (HIS).

Note: Those persons qualifying as "homeless", i.e., those residing in Los Angeles County without an address, may meet the address verification requirements by signing an Affidavit of Residency. Homeless persons shall not be denied non-emergency medical care services on the basis of having no address. Please see Financial Practice 515.11 (revised July 1, 2013), Patient Address Verification.

C. Residency

Los Angeles County residency is a verifiable item. All questions on the ATP Services Agreement pertaining to residence, citizenship and alienage must be completed. Additionally, the following types of clarifying information, if applicable, must be obtained and documented on the ATP Services Agreement:

1. Patient must present acceptable address verification for establishment of Los Angeles County residency (See Section B),

2. If the applicant's birthplace is other than the United States and the applicant is a citizen, an explanation to clarify citizenship/residency must be documented (e.g., date and place of naturalization,); or

3. If the applicant is a lawful permanent resident, the Permanent Resident (Green) Card (1-551) should be photocopied whenever possible and attached to the ATP Service Agreement.

D. Medi-Cal Eligibility

One of the conditions of eligibility for ATP is that, if a patient is potentially eligible for Medi-Cal (i.e., full or restricted benefits with or without a SOC), he/she must apply and fully cooperate in the eligibility determination process before being considered for ATP.

Under the Medi-Cal program, applicants can receive three (3) months retroactive coverage from the month of application, when requested within one year from the application month. Therefore, if applicant/responsible relative(s) is requesting ATP for any of the (three) 3 months prior to the current month, potential eligibility for Medi-Cal must be evaluated.

Note: Not applicable to Hospital Presumptive Eligibility (HPE).

The Medi-Cal Linkage checklist (Exhibit I) is to be used to identify Medi-Cal linkage factors. Neither the linkage checklist nor the Patient Linkage Section of the ATP Services Agreement require verification; however, clarifying information must be documented if any of the answers given are unclear, inconsistent with other information, or in conflict with other known evidence.

The Medi-Cal Linkage checklist should be attached to the original ATP Services Agreement if applicant is not linked.

A Medi-Cal application is required when the patient appears to have linkage. If the patient is potentially linked, the worker must complete the Medi-Cal referral form (Exhibit II) and attach a copy of the linkage checklist when referring the patient to a PFSW or DPSS.

If the Medi-Cal application is denied, either a photocopy of the Medi-Cal Notice of Action Denial Form (MC 239) or a LRS printout reflecting the denial and reason code is to be filed with the ATP Services Agreement.

Note: In order to be eligible for ATP, Medi-Cal must not be denied because of non-cooperation.

Applicants who do not appear to be eligible for Medi-Cal but lack other sources of insurance should be referred to the California Health Benefits Exchange (Covered California.)

E. Patient Pending Benefits

This section does not require verification; however, clarification is necessary if any answers in this section are in conflict with other information provided to complete the ATP Services Agreement.

F. Property

Neither real nor personal property are to be considered for purposes of ATP eligibility.

G. Income

Verification of income is required in order to finalize the application. Income is generally, received by the individual as a result of current or past labor, business activities, interest in real or personal property, or as a contribution from persons, organizations or private assistance agencies.

All income received by the persons listed in the Income Information Section of the ATP Services Agreement must be reported including the amount received, the frequency in which income is received, and whether income is fluctuating or non-fluctuating.

Note: If no income is reported for the family, clarification is required as to how the family's needs are being met. If a patient is living off savings in bank account(s), only interest accrued on the account(s) is counted as income.

As discussed below, most income can be verified by affidavit, which is included in the ATP Agreement. However, the patient should be made aware that the Department may, in its discretion, request other forms of verification at any time during the six (6) months following the date of the application. (See section on Discretionary Post Approval Review, below.)

The Affidavit reads: ATP Patients swear/affirm the following as part of the ATP Agreement, Section IV, ATP Certification: "Such ATP Liability Amount has been determined under the ATP and is based upon information which I/we provide in this Agreement. I/we understand that I/we may be asked later for proof of some or all of the information used for this Agreement. I understand that I am expected to save documents I might have that would help prove that what I said today is true, (for example, copies of pay stubs, income tax returns, bank statements, receipts), for 6 months from the date of the application."

1. Earned Income (Other than Self-Employment).

   Earned income is income received in cash as wages, salary, commission, Disability Insurance Benefits (DIB) (temporary), or persons receiving Workers' Compensation temporarily.

   Verification of earned income is based on the applicant/responsible parties' affidavit.

2. Self-Employment

   Income from self-employment refers to cash received as profit from an activity such as a business enterprise, which is owned or controlled by the applicant/responsible relative(s). Net profit from the self-employment activity is the amount to be used (i.e., gross profit less allowable business expenses) on the ATP Services Agreement. Verification of net profit is based on the applicant/responsible parties' affidavit.

3. Unearned Income

   Unearned income is income that is not earned through labor or personal effort. It includes Unemployment Insurance Benefits (UIB), DIB (permanent), Social Security payments, Veteran's payments, railroad pensions, retirement benefits, contributions from any source, rental of property, interest income, certain grants, support payments, permanently received Workers' Compensation benefits, etc.

   Unearned income generally is received monthly. An exception is UIB/DIB, which is considered to be a weekly benefit received biweekly.

Note: Exclude public assistance income (i.e., SSI/SSP, CalWORKS, etc.).

The gross amount of unearned income is to be shown on the ATP Services Agreement. Any taxes or other deductions withheld from the benefits (including Medicare premiums) must be added back to the net amount received to determine gross unearned income. Verification of unearned income is based on the patient or responsible parties' Affidavit.

H. Income Exclusions

Income received by persons listed in the Family Members Section of the ATP Services Agreement is subject to verification requirements. Certain income, however, can be excluded from consideration in the ATP liability determination.

Note: Exclude family members who are receiving public assistance, (i.e., SSI/SSP and CalWORKS) from family size for purposes of ATP.

1. Earned Income of Children

   a. When the income of a child under 14 years of age is received from earnings, the amount is to be excluded. The parent's statement that the income is from earnings is acceptable verification.

   b. When the income received by a child 14-18 years of age is earnings and the child is attending school full time, this income is to be excluded. The parent's statement that the income is from earnings and that the child is a full-time student is acceptable verification.

   c. These statements must be documented on the ATP Services Agreement.

2. Educational Grants

   Only that portion of the grant, which is specifically for educational purposes (e,g., tuition, books, etc.), can be exempt. Count as income only that portion which is for personal use, (e.g., housing, food, utilities).

   Note: Educational grants may be verified by viewing the grant document to determine its exempt or nonexempt status. The ATP Services Agreement must be documented to show how the grant was evaluated to determine its exempt or nonexempt status. Whenever possible, a copy of the grant document is to be attached to the ATP Services Agreement.

   Education loans should not be considered income to the extent they are required to be repaid.

3. General Relief (GR)

   An applicant participating in Los Angeles County's General Relief Program (GR) is not required to complete a ATP Services Agreement provided verification of

current eligible GR status is available.

There are three acceptable methods for verifying current eligible GR status:

a. The current month's MEDS/LRS clearing showing eligible status,

b. The GR Electronic Benefits Transaction (EBT) card with eligibility confirmed through a Point of Service (POS) device, and

c. Telephone clarification with the recipient's eligibility worker.

I. Income Deductions

Certain income deductions and expenses paid by the applicant or responsible relative(s) are allowable. Verification of income deductions for the month the ATP Services Agreement is effective will be requested. If the applicant cannot provide acceptable verification, the amount cannot be allowed as a deduction.

1. Business Expenses for Self-Employed individuals

Verification of business expenses should be obtained. If the person is self-employed, the reasonable and necessary cost of expenses which are incurred in the production of income (if allowed by the Federal Government for income tax purposes) are to be deducted from gross business profit to determine net profit. Net profit apportioned monthly is the amount of income to be shown on the ATP Services Agreement. (Business expenses may include salary, inventory costs, rent, etc.)

The Federal Income Tax return is the preferable type of verification. However, if the person was not self-employed the previous year, or had not filed an income tax return, or last year's return does not accurately represent current expenses, current business records may be provided for the three months prior to the effective date of the ATP Services Agreement. If both the tax return and current records are unavailable, an affidavit detailing the allowable business expenses is acceptable.

Copies of documents verifying business expenses must be attached to the ATP Services Agreement.

2. Property Expenses Where Income Is Property Related

Verification of property expenses should be obtained, whenever possible. Allowable deductions from income generated by the rental of property may include the monthly interest on encumbrances and, apportioned on a monthly basis, property taxes, insurance, utilities, and upkeep/repairs.

The following are acceptable methods of verifying expenses associated with income from rental property:

a. The amount of interest would be the amount on payment records or an annual interest statement from the lender;

b. Property taxes may be taken from the official tax statement, and apportioned monthly;

c. The cost of insurance payments, including earthquake insurance, would be the amount indicated on the premium notices or a statement from the insurance company, and apportioned monthly;

d. Allow the estimated amount of the last three months of utilities paid by the applicant for this real property and divide total by 3 to determine the average monthly amount;

e. The actual cost of upkeep and repairs is based on the owner's records. Allow the actual amount for the last 6 months and divide total by 6 to determine the average monthly amount.

Photocopies of the documents used as verification are to be attached to the ATP Services Agreement.

J. Family Size

Family size is not a verifiable item; however, when the family includes a pregnant woman, documentation on the ATP Services Agreement is required to clarify whether the unborn is to be included in the Family Size number. For ATP purposes, verification of pregnancy is required; the unborn may be included beginning with the first month of verified pregnancy.

Family members who are receiving public assistance (i.e., SSI/SSP and CalWORKS) are excluded when determining family size; their income from such programs is not counted.

Acceptable verification of pregnancy includes:

1. MEDS or LRS printout, if the patient has pregnancy related Medi-Cal, and

2. A written statement signed by a physician or a person certified as a nurse practitioner, midwife or physician's assistant with access to the patient's medical records, confirming pregnancy.

3. Applicant's declaration of pregnancy, or viewing and documenting on the ATP Services Agreement the following information from the patient's hospital/clinic medical records:

   a. The date of the medical records entry confirming pregnancy,

   b. The expected date of delivery,

c. The name of the physician, certified nurse practitioner, midwife, or physician's assistant who diagnosed the pregnancy and signed the medical records entry,

d. The location of the medical records, and

e. The date the medical records were viewed.

K. Other Coverage

In the event that, during the term of the ATP Agreement the patient becomes eligible for other third party coverage, except Medi-Cal, such as private insurance, the ATP Agreement remains in place and shall be deemed applicable only to patient deductibles and coinsurance, and services that are outside of the scope of the third party coverage.

In the event that the patient becomes eligible for Medi-Cal without a share-of-cost (SOC), and the patient cooperates with the Medi-Cal application process, the ATP Agreement shall remain in place and shall be deemed applicable only to charges for services that are outside of the scope of the third party coverage. In the event that the patient becomes eligible for Medi-Cal with a SOC, the ATP Agreement becomes null and void. The patient must cooperate with the Medi-Cal application process. If the application is granted, the patient may reapply for ATP which will be limited to services outside of the Medi-Cal scope of coverage. Such new ATP agreement may be retroactive to the termination date of the old Agreement. If the patient qualifies as patient with high medical costs as defined in Health and Safety Code § 127400(g), then the patient may apply for assistance under the Discount Payment Plan for the period during which the Medi-Cal application is pending, and for services within the Medi-Cal scope of coverage.

L. Review Process

ATP applicants are to be informed that if they dispute their ATP eligibility or liability amount determinations, they may request a review at the supervisory level within 1O working days of the application decision.

AFFIDAVITS AS VERIFICATION

Except as a source of income verification, affidavits are to be used with restraint. Facility policy, together with these verification guidelines, will determine when an affidavit, which contains all pertinent data, may be substituted as acceptable verification of information provided by a person who is cooperating fully in the application process. The ATP Services Agreement is to be documented to show the reason why an affidavit is being used in lieu of other documents to verify required items and what attempts were made to secure more appropriate or preferred evidence.

DISCRETIONARY POST APPROVAL REVIEW:

As indicated in the ATP Agreement, the Department has retained the right to request during the six months following the month of application, verification of income information previously verified by affidavit. Should the Department chose to exercise this right, it will notify the patient/legally responsible relative in writing of the fact or facts which must be verified and the documents that may be used for such verification, and provide the patient with a reasonable period of time to provide the requested materials.

For earned income the following are acceptable:

a. Paycheck Stubs

For non-fluctuating income, the most recent pay stub may be used.

For fluctuating income, the paycheck stubs should cover a period of at least four current weeks (i.e., not more than a month prior to the date of application for ATP, and not later than the end of the month of the application). The paycheck stubs should be consecutive. If verification for four consecutive weeks cannot be obtained, paycheck stubs received prior to the current period, together with current stubs, may be acceptable verification as long as the paycheck stubs used provide an accurate profile of the person's regular earnings.

Additional documentation is required if current and consecutive paycheck stubs are unavailable and other paycheck stubs for a four week period are used.

b. Federal Income Tax Return

The previous year's Federal Income Tax Return is to be viewed. A copy should be retained.

c. Signed Statement from the person or organization providing the income,

A statement of earnings from the employer must contain all of the following:

i. Individual's gross earnings,

ii. Frequency of earnings,

iii. Employer's signature and the date signed, and

iv. Employer's business address and phone number.

If the worker initiates the request for income verification directly to the employer, an ABCDM 228 (or facsimile) – Exhibit V, listing in detail the information to be requested and signed by the employed person, must be attached to the request for income verification.

Note: An ABCDM 228, Authorization for Release of Information (or facsimile) must be attached to each request for verification except for government agencies. PFS Memo 16-80 provides a format for securing income information, including a space for the person's authorization. If this format is used, a separate ABCDM 228 is not required.

The employer's statement and copy of ABCDM 228 (when required) are to be attached to the ATP Services Agreement. Additionally, reference to the statement of earnings is to be noted on the ATP Services Agreement.

For Income from Self-employment, the following forms of verification will be acceptable:

a. Federal Income Tax Return

The previous year's Federal Income Tax Return is to be viewed to determine net profit. This amount is used as an estimation of annual net profit for the current year. Annual net profit is apportioned monthly.

A copy of the Federal Income Tax Return for the business should be retained. If a copy cannot be retained, the file must be documented to show in detail how net profit was determined, the documents viewed, etc.

b. Current Business Records

The Federal Income Tax return is the preferable type of verification. If the person was not self-employed the previous year, or, for some reason, had not filed an income tax return, or if the previous year's income tax return is not representative of current income, current business records are acceptable verification.

Copies of these records should be included in the file, or the file must be documented to include the types of documents viewed, allowable business expenses deducted, how net profit was determined, etc.

For Unearned Income, the following forms of verification will be acceptable:

a. Income Tax Returns

b. Checks (or Copies of Checks) or Check Stubs

Unearned income may be verified by viewing the current month's check, provided that the amount shown represents gross benefits. If the patient indicates that the amount represents a net benefit (i.e., taxes or other amounts have been deducted), one of the other alternate methods of verification should be used unless the check can be combined with other documents to provide an accurate profile of gross income.

c. Other Documents

In the event and only in the event that the individual cannot produce either of these forms of documentation, these alternatives may be requested.

i. Award Letters (e.g., Social Security Administration, Disability Insurance Benefits, etc.)

An award letter is a written notice sent to the recipient of the income identifying the type of benefits, the effective date, the amount, and the frequency of receipt.

The award letter is acceptable verification if it shows the amount of current benefits (i.e., it must have been issued since the last benefit increase).

ii. Signed Statement from person or organization providing the income.

A statement signed and dated by the person or organization providing unearned income is acceptable verification. The statement must include the amount, frequency and type of income received.

If the worker initiates the request for income verification directly to the provider of the income, an ABCDM 228 (or facsimile), authorizing the provider to release the information, must be signed by the individual and attached to the request for information.

To the extent possible photocopies of the documents used to verify unearned income (except U.S. Government checks) are to be included in the file. (The California Department of Health Care Services has prohibited the photocopying of any U.S. Government check, such as Social Security or Veteran's benefits.) When photocopies of verifying documents are unavailable, or U.S. Government checks are being used as verification, the file must be annotated to show the type and date of the verification seen, as well as the amount and the frequency of the income received.

Note: Per Health & Safety Code §127405, the minimum standard for proof of income is recent pay stubs or income tax returns. For purposes of ATP eligibility determination, this minimum standard cannot be exceeded but it is acceptable to allow the patient to provide alternate documentation as indicated above.

Exhibit V

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

(AGENCY OR INDIVIDUAL FROM WHOM INFORMATION IS REQUESTED)

To:

I, _____, RESIDING AT _____

_____, HEREBY AUTHORIZE YOU TO RELEASE TO THE

(NAME OF AGENCY, INSTITUTION, INDIVIDUAL PROVIDER) SPECIFIC

INFORMATION REQUESTED BY THIS AGENCY WHICH I CANNOT PROVIDE CONCERNING _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE _____

THIS FORM WAS COMPLETED IN ITS ENTIRETY AND WAS READ BY ME (OR READ TO ME) PRIOR TO SIGNING

SIGNATURE OF APPLICANT		DATE
BIRTHPLACE	BIRTHDATE	MAIDEN NAME OF MOTHER
SIGNATURE OR NAME OF SPOUSE		DATE
BIRTHPLACE OF SPOUSE	BIRTHDATE OF SPOUSE	MAIDEN NAME OF SPOUSE'S MOTHER

ABCDE 230 (REVISED) (6/89)

Financial Practice

Department of Health Services

RELEASE NO. 520.28

RELEASED December 1, 2007

EFFECTIVE December 1, 2007

REVISED January 1, 2015

DISCOUNT PAYMENT PLAN (DPP) GUIDELINES

PURPOSE: To establish uniform guidelines for implementing DPP.

GENERAL: The DPP is available to patients who receive either inpatient or outpatient care at a county hospital who (1) are either Self-Pay or have a high medical cost as defined below, and (2) have family income that does not exceed 350% of the Federal Poverty Level (FPL).

For persons other than Los Angeles (LA) County residents and Medi-Cal beneficiaries with a Share-of-Cost (SOC), the DPP serves as the LA County Department of Health Services (DHS) discount payment plan for purposes of Health and Safety Code §127405. The DPP is offered at the DHS hospitals and hospital based clinics only.

Generally out-of-county and out-of-country foreign visitor and non-immigrant (OOC/OOC/FV/NP) patients are ineligible for non-emergency medical care services in Los Angeles County facilities. In those facilities where there is excess capacity, OOC/OOC/FV/NP patients may be eligible to receive non-emergency medical care services pursuant to the requirements of Policy 516.1 – Non-Emergency Medical Care Services Requirements - OOC/OOC/FV/NP.

NOTE: Completion of a DPP Agreement does not negate Policy 516.1. Patients should be deferred for non-emergency services, as appropriate.

For procedures regarding address identification of persons with OOC/OOC/FV/NP status, referral for medical assessment, referral to an alternate care setting for non-emergency medical services if proof of adequate third-party coverage is not received see Financial Practice 516.11 - Non-Emergency Medical Care Services Requirements - OOC/OOC/FV/NP.

For LA County residents at or below 350% FPL, DPP will cover:

1) Non-medically necessary cosmetic surgery and infertility care services, which are not covered by ATP:

2) Services paid in full by a patient, who chooses not to report services to their insurance under Health Information Exchange (HIE);

3) All services provided to Medi-Cal beneficiaries with a share-of-cost (SOC) who qualify as patients who have high medical costs; and
4) All services provided to persons who have applications for Medi-Cal or other third party coverage pending and who want to be covered by one of the County plans in the interim.

NOTE: If patient or family income exceeds 350% FPL, the patient is not eligible for the DPP and is responsible for the full cost of care.

DEFINITIONS:

Out-of-County Persons means those persons with a residence that is in the United States, but outside Los Angeles County.

Out-of-Countrv/FV/NP means those persons who are considered to have a legal residence that is outside the United States and also have Out-of-Country/FV/NP status. To determine Out-of-Country/FV/NP status, see Financial Practice 516.11.

LA County Resident means a person who lives in the LA County whenever not called away for work or school and who is not deemed to have a residence outside of the LA County by virtue of any law or regulation.

Self-pay means a patient who does not have third-party coverage from a health insurer, health care service plan, employer sponsored plan, Medicare, Medi-Cal or other government sponsored program, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, liability coverage or other insurance as determined and documented by the hospital. Self-pay patients include individuals who have signed a Self-Pay Fast-Track Agreement and now are seeking further discounts.

Having high medical cost means (1) annual out-of-pocket costs incurred by the individual at the hospital exceed 10 percent of the patient's family income in the prior 12 months, or (2) annual out-of-pocket expenses paid by patient or patient's family for the patient's medical expense in the prior 12 months exceed 10 percent of the patient's family income.

Patient's family means: (1) for patients 18 years of age and older: spouse, (including same-sex), domestic partner (i.e., same sex partners who are legally registered with the State), and dependent children under 21 years of age, whether living at home or not, or (2) for patients under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

Legally responsible relative means: "responsible relative" as defined in California Code of Regulations, Title 22 Section 50351.

RESPONSIBILITY: The Facility Finance Directors shall be responsible for the implementation of, and compliance with, this Practice.

PROCEDURES: See detailed procedures attached.

NOTED AND APPROVED:

Allan Wecker
Chief Financial Officer
Subject to Revision 1st quarter 2015

RELEASE NO. 520.28

RELEASED December 1, 2007

EFFECTIVE December 1, 2007

REVISED January 1, 2015

PROCEDURES

SUBJECT: DPP Guidelines.

SCOPE: These procedures include the actions to be taken by the financial staff of each facility to complete and verify DPP.

PROCESSING MATERIALS:

Exhibit I	Medi-Cal Linkage Checklist
Exhibit II	Medi-Cal Referral Form
Exhibit III	Discount Payment Plan Agreement
Exhibit IV	Discount Payment Plan Processing Guidelines
Exhibit V	ABCDM 228 - Applicant's Authorization For Release of Information

RELEASE NO. 520.28

RELEASED December 1, 2007

EFFECTIVE December 1, 2007

REVISED January 1, 2015

RESPONSIBILITY	ACTION REQUIRED
Patient Financial Services/Eligibility Staff	I. Per existing procedures, financially screen and refer the patient for a DPP interview, as appropriate.
	II. Begin DPP interview.
	111. Advise the patient that DPP covers inpatient or outpatient medical care services provided at Los Angeles County Department of Health Services (DHS) hospitals and hospital based clinics for qualified individuals. A separate application must be made for each inpatient admission; however, a single application may be made for all outpatient services received during a single 12 month period.
	IV. Verify the patient's and/or patient's responsible relative(s) temporary and/or permanent address (see Financial Practice 515.11).
	V. Verify the patient's and/or patient's responsible relative(s) identity (see Financial Practice 370.11).
	VI. Verify patient's status as OOC/OOC/FV/NP (See Policy 516.1).
	VII. Complete Medi-Cal Linkage Checklist (Exhibit I) and utilizing the Medi-Cal Referral Form (Exhibit II), refer linked patients to apply for Medi-Cal, if potential eligibility exists. Refer patients to the California Health Benefits Exchange (Covered CA), if they appear eligible. If appropriate, make them aware that they may have to wait until the next open enrollment period to apply. Do not stop processing the application while the Medi-Cal application is being processed. Inform the patient that, if he/she becomes Medi-Cal eligible, the DPP Agreement will limited to any cost sharing amounts, or charges for services that are outside of the scope of Medi-Cal coverage, effective on the date Medi-Cal coverage begins. If the patient refuses

RELEASE NO. 520.28

RELEASED December 1, 2007

EFFECTIVE December 1, 2007

REVISED January 1, 2015

ACTION REQUIRED

RESPONSIBILITY

to cooperate with the Medi-Cal application process, continue to process the application for DPP.

Patient Financial Services/Eligibility Staff

VIII. Complete Section I of the Discount Payment Plan Agreement (Exhibit III) - Patient Information, Part A - Income Calculation, Part B – Liability Determination and

Section II Income Information utilizing the DPP Guidelines (Exhibit IV), based on information provided by the patient and/or patient's responsible relative(s).

IX. If family income is greater than 350% FPL, inform the patient that he/she is ineligible for the DPP, and is responsible for the full cost of care.

X. If ineligible, inform the patient of his/her right to seek review of the decision and provide information on how to make a request for review.

XI. If family income is less than or equal to 350% FPL, continue.

XII. Determine those DPP Agreement information items to be verified, e.g., income, in accordance with Exhibit IV.

XIII. Request verification for DPP Agreement information items, as required in Exhibit IV, from the patient and/or the patient's responsible relative(s).

XIV. Explain to the patient and/or the patient's responsible relative(s) acceptable methods of verification.

XV. Allow the patient and/or the patient's responsible relative(s) up to a maximum of 30 calendar days from the date of the original request to provide verification.

XVI. Deny the DPP application if verification is not provided within 30 calendar days from the date of the original request, or Complete Section III - Discount Program Certification of the

RELEASE NO.: 520.28

RELEASED: December 1, 2007

EFFECTIVE: December 1, 2007

REVISED: January 1, 2015

ACTION REQUIRED

RESPONSIBILITY

DPP, if verification is provided.

Patient Financial Services/Eligibility Staff

XVII. Review DPP Certification Section with patient/responsible relative(s) to confirm their understanding of the agreement.

XVIII. Inform the patient that for the time period covered by the DPP Agreement, he/she must report any changes in his/her financial circumstances, or family size as these factors could impact DPP eligibility.

XIX. Inform the patient that if it is determined that the patient is eligible for any form of third party coverage, including health insurance or coverage by a tortfeasor but excluding Medi-Cal, discounts under the DPP agreement shall only apply to the patient responsible amount (e.g., deductible coinsurance, or non-covered services). For Medi-Cal beneficiaries, the discount applies to the hospital's gross charges and not just the patient responsible portion.

XX. Approve the DPP Agreement, if the patient and or responsible relative(s) have met all other eligibility requirements.

XXI. Update the Health Information System (HIS) with appropriate standardized carrier code(s).

XXII. Explain effective dates (from/through) for the DPP Agreement to the patient.

Note: The DPP Agreement is effective for one (1) year for outpatient services or for each admission for inpatient services.

XXIII. Update the HIS with the DPP Agreement effective dates.

RELEASE NO.: 520.28

RELEASED: December 1, 2007

EFFECTIVE: December 1, 2007

REVISED: January 1, 2015

ACTION REQUIRED

RESPONSIBILITY

Patient Financial Services/Eligibility Staff

XXIV. Explain the DPP liability amount to the patient. If the patient is eligible for the DPP, the patient's liability amount shall not be greater than the amount the facility would receive from the Medi-Cal program for the same service to a Medi-Cal eligible patient. If the amount the facility would receive from the Medi-Cal program exceeds charges, the patient's liability amount shall be no greater than 95% of the patient's undiscounted liability amount. However, for Medi-Cal beneficiaries, the 5% reduction is made to gross charges, not the patient liable amount.

XXV. Inform the applicant that, if they dispute their DPP eligibility or liability amount determination, they may request a review at the supervisory level within 10 working days of the decision.

XXVI. Inform the patient that he/she has the option to make payment for his/her liability via an Extended Payment Plan agreement. The Extended Payment Plan agreement will allow the patient to make payment of his/her liability over time. See Financial Practice 520.27 – Extended Payment Plan rules.

XXVII. Provide a copy of the DPP Agreement to the patient and maintain a copy in file.

If the patient or the patient's authorized representative claims that his/her Medi-Cal application has been denied, but the denial is being appealed, and he/she makes a reasonable effort to inform the hospital about the progress of a pending Medi-Cal appeal, the hospital should not refer the patient's liability to collection unless a final negative determination of that appeal is made.

RELEASE NO.: 520.28

RELEASED: December 1, 2007

EFFECTIVE: December 1, 2007

REVISED: January 1, 2015

ACTION REQUIRED

RESPONSIBILITY

Patient Financial Services/Eligibility Staff

XVIII. If the patient previously paid the hospital in excess of the amount due, the hospital shall reimburse the excess of the amount due and interest at a rate of 10% per annum, starting on the date payment is received.

Failure of the patient to provide information required for the hospital to make an eligibility determination for the DPP will make the patient ineligible. However, eligibility for DPP may be determined later, if the hospital actually receives required information.

CROSS REFERENCE:

Extended Payment Plan, Financial Practice 520.27

Patient Address Verification, Financial Practice 515.11

Patient Identity Verification, Financial Practice 370.11

Health and Safety Code §127400 and subsequent

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

MEDI-CAL LINKAGE CHECKLIST

Date Completed:_____Patient:_____MRUN #:_____

Financial Screener:_____Facility:_____Admission Outpatient Date:_____

Hospital Presumptive Eligibility (HPE)

(If "Yes" is answered to any question below, HPE Medi-Cal linkage exists. Refer patient to PRW/PFSW)

Evaluate if potentially eligible for HPE benefits (Hospital Inpatient and Outpatient*), is patient:

a) Between age 19-26 and in foster care on the month of their 18th birthday? Yes D No D
b) A Child (ages 0-18) at or below 266% of the Federal Poverty Level (FPL)? Yes D No D
c) A Parent, caretaker relative or a "new adult" (ages 19-64) at or below 138% FPL? Yes D No D
d) A pregnant woman at or below 213% FPL (outpatient prenatal and pregnancy related services only)? Yes D No D

NOTE: To be eligible under the above categories, individuals must be uninsured California residents (i.e., no coverage such as private insurance, Medicare, Medi-Cal, etc.). To be eligible in the first three categories, the individual must not be pregnant.

* Inpatient and Hospital based Outpatient only.

Eligibility Screening:

If "Yes" is answered to anv question below; STOP Medi-Cal linkage exists. If linkage exists, refer patient to PFSW, on-site Eligibility Worker, or DPSS office for Medi-Cal.

A. EVALUATION STEP

1. Is patient age 19 or older and under age 65,
   AND
   Does patient have a household income at or below 138 percent of the Federal Poverty Level for the applicable family size?
   Number in Household Gross Income $ Yes ☐ No ☐
2. Is patient 65 years of age or over? Yes ☐ No ☐
3. Is patient under 21 years of age? Yes ☐ No ☐
4. Is patient pregnant? Yes ☐ No ☐
5. Is patient a caretaker relative of children, (e.g., grandchildren, niece/nephew, cousin, brother/sister) in the home under 21? Yes ☐ No ☐
6. Is patient a stepparent? Yes ☐ No ☐
   "Stepparent may be eligible if parent of separate child(ren) is in the home."
7. Is patient blind (i.e., visual acuity *201200* with correction or tunnel vision)? Yes ☐ No ☐
8. Is patient disabled, (i.e., has a physical mental condition which prevents him/her from working for at least a year or will result in death)? [f patient is receiving *Social Security/Railroad Retirement Disability Benefits,* he/she is disabled.] Yes ☐ No ☐
9. Is patient residing in a Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF)? (Note: This category only covers SNF/ICF and outpatient care.) Yes ☐ No ☐

If "Yes" is answered to at least one of the above questions, Medi-Cal linkage exists.

If linkage exists, refer patient to PFSW, on-site Eligibility Worker, or DPSS for Medi-Cal application. Attach Medi-Cal Linkage Checklist to Medi-Cal Referral Form.

Health Services
LOS ANGELES COUNTY

313 N. Figueroa Street, Suite 518
Los Angeles, CA 90012

Tel: (213) 240-8277
Fax: (213) 240-8028

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

Date: _____

TO: Department of Public Social Services/Patient Financial Services

FROM: _____ _____
(Worker's Name) (Facility)

SUBJECT: **REFERRAL FOR MEDI-CAL APPLICATION**

MRUN # _____ Date of Birth _____
Patient's Name _____

We are referring the above person to apply for Medi-Cal. He/she appears to meet the Medi-Cal eligibility requirements. (Refer to attached Medi-Cal Linkage Checklist.) The patient is currently receiving health care services from our Department.

Mr. /Mrs. has applied for the County's Discount Payment Plan (DPP). However, the patient appears to be eligible for Medi-cal, and that may result in lower costs to the patient, or better access to care, if true. The patient identified above will be eligible for benefits under the DPP during the pendency of a Medi-Cal application or if he/she does not cooperate with the Medi-Cal process; however, we would encourage you to help the patient understand the value of the Medi-Cal benefits before he/she makes a decision not to cooperate.

Thank you for your cooperation in this matter. If you have any questions or need additional information, please call me at ( )_____

Attachment:

DPSS/PFS:
If an application is not taken for patient, please indicate reason for ineligibility and return form to patient.

_____
_____
_____

Worker's Name _____
Telephone No. (_____

www.dhs.lacounty.gov

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

DISCOUNT PAYMENT PLAN AGREEMENT (INPATIENT/OUTPATIENT)*

(Please Print)

Facility: MRUN # Inpt. Admit Date Outpt. Date

SECTION I: PATIENT INFORMATION

Patient:_____ DOB:_____ Social Security #: _____

Permanent Address:_____ City:_____ Country/State/County: _____ Zip:_____

Telephone: [Home] _____ [Work] _____ [Message] _____

Local Address: _____

SECTION II: INCOME INFORMATION:

Family size _____ Grand Total Monthly Gross Income - [Enter from Worksheet, Part A. 4 or E. 3] $_____	DISCOUNT PAYMENT PLAN ELIGIBILITY: (County Use Only) Family income less than or equal to 350% FPL: D Yes (eligible) D No (ineligible)

SECTION III: DISCOUNT PAYMENT PLAN CERTIFICATION:

I certify that, as of today's date, I, (or patient), do/(does) not have Medi-Cal, Medicare, Short Doyle, CHAMPUS, California Children Services, or private health insurance, or any other form of health care coverage for the condition for which the patient is being treated.

In consideration for being charged for health care services rendered by the County of Los Angeles (County) in accordance with the County's Discount Payment Plan, I/we _____ promise to pay the County (check one):

☐ INPATIENT: For all inpatient services received by the patient covered by this Agreement from admit date of _____ until discharged from the County's Health care facility, the Discount Payment Plan Liability Amount of _____ dollars ($_____ per day for such inpatient stay of admission or 95% of the patient liable amount for person with health care coverage (except Medi-Cal beneficiaries with a share of cost) , whichever is less; or for persons without health care coverage and Medi-cal beneficiaries with a share of cost, $ per day for such inpatient stay of admission or 95% of gross charges, whichever is less OR

☐ OUTPATIENT: For all outpatient services received by the patient covered by this Agreement from _____ through_____ ,_____ , the Discount Payment Plan Liability Amount of _____ dollars ($ for each outpatient visit during such period or 95% of the patient liable amount for person with health care coverage (except Medi-Cal beneficiaries with a share of cost) or for persons without health care coverage and Medi-Cal beneficiaries with a share of cost), $_____ for each outpatient visit during such period or 95% of gross charges, whichever is less.

Pursuant to Section 360.5 of the California Code of Civil Procedure, which allows written waivers related to actions for the repayment of County aid, I/we hereby waive all statues of limitation upon collection of debt covered by this Agreement.

I/we certify that, during the next year, if the patient gets or loses insurance, or if his or her family size or income changes, I/we promise to immediately report that fact to the facility where this form was completed.

It is agreed that if I/we have a change in financial circumstances, including but not limited to an increase in the patient's or guarantor's income, or the patient, or patient's heirs or personal representative(s), receipt of damages recovered as a result of patient's injury by accident, negligence, or wrongful act, I/we will notify the facility where this Agreement was completed and this Agreement may, at the election of the County of Los Angeles, be terminated, and the County's hospital shall be entitled to its reasonable charges.

This agreement shall not in any way diminish or defeat the County's right, under California Government Code Sections 23004.1 and 23004.2, or the Hospital Lien Act, or any other applicable laws to recover reimbursement from any responsible third-parties, including tortfeasors, the reasonable charges for health care services provided to the patient.

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE PROVIDED AS REQUESTED IN THIS AGREEMENT IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY BY MY/OUR SIGNATURES(S) THAT I/WE HAVE READ AND UNDERST AND ALL THE FOREGOING AND THAT I/WE AGREE TO SIGN THIS STATEMENT WITHOUT ANY RESERVATION WHATSOEVER.

Patient/Responsible Relative Signature: _____ Date: _____

County Interviewer: (Print Name) _____ Telephone No.: (__)_____

(Signature) _____ Date:_____

(Supervisor's Signature) _____ Date: _____

Check box, if applicable:

o Patient not eligible for Medi-Cal/Medicaid.

* Discount Payment Plan Agreement intended *for* non-LA County Residents. Also intended for LA County Residents for non-medically necessary cosmetic surgery and infertility related care, which is not covered by ATP, or who are Medi-Cal beneficiaries with high medical costs or persons with health care applications pending.

Exhibit IV

APPLICATION PROCESSING GUIDELINES FOR DISCOUNT PAYMENT PLAN (DPP)

GENERAL

Before eligibility for DPP can be established, certain information must be disclosed by the patient/responsible relative(s) in connection with the DPP.

A patient may submit a Medi-Cal application if linked to the program. To be eligible for the DPP, the patient must have charges which won't be covered by Medi-Cal, Medicare, private insurance or other medical benefits. If the patient refuses to cooperate with the Medi-Cal application process, continue to process the application for DPP anyway.

Note: Verification of income is required in order to finalize DPP application. Additionally, when such information is unclear or in conflict, additional clarification must be requested and the clarifying information recorded.

DEFINITIONS:

Verification means the act of obtaining evidence, which either confirms or invalidates the facts asserted by the patient and/or patient's responsible relative(s).

Clarification means the act of obtaining additional information in order to resolve unclear or inconsistent statements made in connection with the DPP application.

Note: In some situations, clarification and verification may be the same. A document which could provide clarification may also be acceptable as verification, if verification were required.

Documenting means to attach supporting evidence to the DPP Agreement. To the extent possible, acceptable documentation consists of the original or a photocopy of the verifying/clarifying information.

When an entry is to be made in lieu of attaching evidence that entry must include:

- The reason why the document was viewed rather than attached,
- The type and date of document viewed,
- All pertinent information from the document including identifying data and specific facts which support the statements to be verified,
- The date the document was viewed, and
- The interviewer's initials.

Responsible relative means "responsible relative" as defined in California Code of Regulations, Title 22, Section 50351.

RESPONSIBILITY FOR VERIFICATION/CLARIFICATION

The applicant and/or responsible relative(s) have the primary responsibility for providing any requested information or verification/clarification. Primary responsibility means that applicant/responsible relative(s) must obtain and provide requested information or evidence necessary to verify or clarify the required items on the DPP Agreement.

Note: Applicant is to be informed of alternate methods for verification, if necessary, (e.g., statement from employer regarding earnings if he/she didn't save pay stubs, previous year's Income Tax Return, etc.).

When the applicant/responsible relative is cooperative but through no fault of his or her own has been unable to obtain the evidence needed, the interviewer may initiate a request for verification directly to an outside person/organization which would have the information. A completed ABCDM 228, Applicant's Authorization for Release of Information, or facsimile, signed by the applicant/responsible relative(s) must be attached to each request for verification made to a person/organization other than the applicant/responsible relative(s).

If, after initiating the ABCDM 228 along with a request for information, the interviewer is still unable to obtain needed information, an Affidavit may be used as a last resort to obtain evidence needed, (e.g., applicant originally had pay stubs but did not save them and the employer will not provide a written statement).

If the applicant never had written verification (e.g., day laborer who gets paid cash, etc.), an Affidavit may be considered on a case by case basis. When the applicant/responsible relative(s) is cooperative with the verification process, but through no fault of his/her own has been unable to obtain or provide the evidence needed, the interviewer may:

- Document all actions taken to obtain evidence required for verification, and
- Secure from the applicant/responsible relative(s) an Affidavit dated and signed under penalty of perjury which lists and describes the evidence in the same detail as would be required of acceptable verification.

ITEMS REQUIRING VERIFICATION/CLARIFICATION DOCUMENTATION

A. Social Security Number (SSN)

The SSN should be verified, <u>whenever p</u>ossible.

Note: Inability of the applicant to provide evidence of a SSN does <u>not</u> constitute a basis for ineligibility for DPP.

Verification includes, but is not limited to:

1. Social Security card,
2. Award letter [e.g., Social Security Administration (SSA), Disability Insurance Benefits, etc.],

3. Medicare card,

4. Check from SSA which shows the applicant's name and SSN with the suffix A, HA, J, T, or M,

5. Correspondence from SSA,

6. Paycheck stubs and/or company ID badge/card which specify both the applicant's name and SSN, and

7. Medi-Cal Eligibility Data System (MEDS) with a Social Security "J" verifier.

Documentation for the DPP Agreement should include the original, a photocopy of the evidence, or description of how the SSN was verified.

If the applicant does not have an SSN and if the applicant is eligible to have an SSN, he/she should be encouraged to apply for one. The lack of an SSN should be documented on the DPP Agreement. Further, the interviewer should inform the applicant to retain, for future reference, any correspondence from SSA related to applying for an SSN.

SSN verification is not required from other family members. However, if SSN verification is available, the interviewer should document that verification on the DPP Agreement. If any family member does not have an SSN, he/she should be encouraged to apply for one and retain any correspondence from SSA.

B. Address

Los Angeles County residency is not required for the DPP Agreement. However, current address verification is required. The patient's current address is to be verified if it is not the same address used when the patient received services. If the patient's current address is the same address used when the patient received services, and the address has already been verified, additional verification is not required. The following documents are acceptable examples of current address verification, in order of preference:

1. Valid California Driver's License,

2. Valid Department of Motor Vehicles (DMV) Identification Card,

   Note: Short term DMV Identification Card that expires when foreign visitor documentation expires is not acceptable for purposes of address verification.

3. Government issued identification card with the patient's or legally responsible relative's picture and address (e.g., Matricula Consular, etc.),

4. School Identification,

5. General Relief Identification (EBT Card),

6. Utility Bill,

7. Any mailing addressed to patient/responsible relative(s) and cancelled by the U.S. Post Office, and

8. Rent receipt or letter from provider verifying in-kind residential address.

Note: For 6, 7, and 8, above, documentation dated within 60 days of the date presented shall be considered current.

Case file should reflect how the address was verified, and this information should be recorded in the Health Information System (HIS).

Note: Those persons qualifying as "homeless", i.e., those residing in Los Angeles County without an address, may meet the address verification requirements by signing an Affidavit of Residency. Homeless persons shall not be denied non-emergency medical care services on the basis of having no address. Please see Financial Practice 515.11 (revised July 1, 2013), Patient Address Verification.

Address verification affidavits can also be used for patients who are 1) living in shelters, 2) living in the home of another, or 3) residing in rural areas without postal services, and/or seeking specific medical services, family planning, or DHS mental health services.

C. Medi-Cal Eligibility

A patient may apply for a Medi-Cal application if linked to the program. If the patient refuses to cooperate with the Medi-Cal application process, continue to process the application for DPP.

Under the Medi-Cal program applicants can receive three (3) months retroactive coverage from the month of application, if requested within one year from the application month. Therefore, if applicant/responsible relative(s) is requesting DPP for any of the three (3) months prior to the current month, potential eligibility for Medi-Cal must be evaluated.

Note: Not applicable to Hospital Presumptive Eligibility (HPE).

The Medi-Cal Linkage checklist (Exhibit I) is to be used to identify potential Medi-Cal eligibility. The linkage checklist does <u>not</u> require verification; however, clarifying information must be documented if any of the answers given are unclear, inconsistent with other information, or in conflict with other known evidence.

A Medi-Cal application may be completed when the patient appears to have linkage. If a patient is potentially linked, the worker should complete a Medi-Cal Referral form (Exhibit II) and attach a copy of linkage checklist when referring the patient to DPSS, an on-site EW or PFSW.

If the Medi-Cal application is denied, either a photocopy of the Medi-Cal Notice of Action Denial Form (MC 239) or a LRS printout reflecting the denial and reason code is to be filed with the DPP Agreement.

D. Property

Neither real nor personal property are to be considered for purposes of DPP.

E. Income

Verification of income is required in order to finalize the application. Income, generally, is any benefit in cash which is currently available to the individual or received by him/her as a result of current or past labor, business activities, interest in real or personal property, or as a contribution from persons, organizations or private assistance agencies.

All income received by the persons listed in the Income Information Section of the /DPP Agreement must be reported including the source, amount received, the frequency in which income is received, and whether income is fluctuating or non-fluctuating.

Note: If no income is reported for the family, clarification is required as to how the family's needs are being met. If patient is living off savings in bank account, only interest accrued on the account is counted as income.

1. Earned Income (Other than Self-Employment).

Earned income is income received as wages, salary, commission, Disability Insurance Benefits (DIB) (temporary), or temporary Workers' Compensation.

Acceptable verification of earned income includes:

a. Paycheck Stubs

For non-fluctuating income, the most recent pay stub may be used.

For fluctuating income, the paycheck stubs should cover a period of at least four current weeks (i.e., not more than a month prior to the date of application for DPP, and not later than the end of the month of the application). The paycheck stubs should be consecutive. If verification for four consecutive weeks cannot be obtained, paycheck stubs received prior to the current period, together with current stubs, may be acceptable verification as long as the paycheck stubs used provide an accurate profile of the person's regular earnings.

Copies of the paycheck stubs used as verification are to be attached to the DPP Agreement. Additional documentation is required if current and consecutive paycheck stubs are unavailable and other paycheck stubs for a four week period are used.

b. Federal Income Tax Return

The previous year's Federal Income Tax Return is to be viewed and a copy attached to the DPP Agreement.

c. Signed Statement from the person or organization providing the income,

A statement of earnings from the employer must contain all of the following:

i. Individual's gross earnings,

ii. Frequency of earnings,

iii. Employer's signature and the date signed, and

iv. Employer's business address and phone number.

If the worker initiates the request for income verification directly to the employer, an ABCOM 228 (or facsimile) – Exhibit V, listing in detail the information to be requested and signed by the employed person, must be attached to the request for income verification.

Note: An ABCOM 228, Authorization for Release of Information (or facsimile) must be attached to each request for verification except for government agencies. PFS Memo 16-80 provides a format for securing income information, including a space for the person's authorization. If this format is used, a separate ABCOM 228 is not required.

The employer's statement and copy of ABCOM 228 (when required) are to be attached to the DPP Agreement. Additionally, reference to the statement of earnings is to be noted on the DPP Agreement.

2. Self-Employment

Income from self-employment refers to payment received as profit from an activity such as a business enterprise, which is owned or controlled by the patient/responsible relative(s). Net profit from the self-employment activity is the amount to be used (i.e., gross profit less allowable business expenses) on the DPP Agreement. Net profit can be obtained either from last year's income tax return or from current business records.

Acceptable verification of net profit includes:

a. Federal Income Tax Return

The previous year's Federal Income Tax Return is to be viewed to determine net profit. This amount is used as an estimation of annual net profit for the current year. Annual net profit is apportioned monthly.

A copy of the Federal Income Tax Return for the business should be attached to the DPP Agreement. If a copy cannot be attached, the DPP Agreement must be documented to show in detail how net profit was determined, the documents viewed, etc.

b. Current Business Records

The Federal Income Tax return is the preferable type of verification. If the person was not self-employed the previous year, or, for some reason, had not filed an income tax return, or if the previous year's income tax return is not representative of

current income, current business records are acceptable verification.

Copies of these records should be attached to the DPP Agreement or the DPP Agreement must be documented to include the types of documents viewed, allowable business expenses deducted, how net profit was determined, etc.

3. Unearned Income

Unearned income is income that is not earned through labor or personal effort. It includes Unemployment Insurance Benefits (UIB), DIB (permanent), Social Security payments, Veteran's payments, railroad pensions, retirement benefits, contributions from any source, rental of property, interest income, certain grants, support payments, permanently received Workers' Compensation benefits, etc.

Unearned income generally is received monthly. An exception is UIB/DIB, which is considered to be a weekly benefit received biweekly.

Note: Exclude public assistance income (i.e., SSI/SSP, CalWORKS, etc.).

The gross amount of unearned income is to be shown on the DPP Agreement. Any taxes or other deductions withheld from the benefits (including Medicare premiums) must be added back to the net amount received to determine gross unearned income.

Acceptable verification of unearned income includes:

a. Income Tax Returns

b. Checks (or Copies of Checks) or Check Stubs

Unearned income may be verified by viewing the current month's check, provided that the amount shown represents gross benefits. If the applicant indicates that the amount represents a net benefit (i.e., taxes or other amounts have been deducted), one of the other alternate methods of verification should be used unless the check can be combined with other documents to provide an accurate profile of gross income.

c. Other Documents

In the event and only in the event that the individual cannot produce either of these forms of documentation, these alternatives may be requested:

i. Award Letters (e.g., Social Security Administration, Disability Insurance Benefits, etc.)

An award letter is a written notice sent to the recipient of the income identifying the type of benefits, the effective date, the amount, and the frequency of receipt.

The award letter is acceptable verification if it shows the amount of current benefits (i.e., it must have been issued since the last benefit increase).

ii. Signed Statement from person or organization providing the income.

A statement signed and dated by the person or organization providing unearned income is acceptable verification. The statement must include the amount, frequency and type of income received.

If the worker initiates the request for income verification directly to the provider of the income, an ABCDM 228 (or facsimile), authorizing the provider to release the information, must be signed by the individual and attached to the request for information.

To the extent possible photocopies of the documents used to verify unearned income (except U.S. Government checks) are to be attached to the DPP Agreement. (The California Department of Health Care Services has prohibited the photocopying of any U.S. Government check, such as Social Security or Veteran's benefits.) When photocopies of verifying documents are unavailable, or U.S. Government checks are being used as verification, the DPP Agreement must be documented to show the type and date of the verification seen, as well as the amount and the frequency of the income received.

Note: Per Health & Safety Code §127405, the minimum standard for proof of income is recent pay stubs or income tax returns. For purposes of DPP eligibility determination, this minimum standard cannot be exceeded but it is acceptable to allow the patient to provide alternate documentation as indicated above.

F. Income Exclusions

Income received by persons listed as household members in the Income Information Section of the DPP Agreement is subject to verification. Certain income, however, can be excluded from consideration in the DPP liability determination.

Note: Exclude family members who are receiving public assistance, (i.e., SSI/SSP and CalWORKS) from family size for DPP.

1. Earned Income of Children

a. When the income of a child under 14 years of age is received from earnings, the amount is to be excluded. The parent's statement that the income is from earnings is acceptable verification.

b. When the income received by a child 14-18 years of age is earnings and the child is attending school full time, this income is to be excluded. The parent's statement that the income is from earnings and that the child is a full-time student is acceptable verification.

c. These statements must be documented on the DPP Agreement.

2. Educational Grants

Only that portion of the loan/grant, which is specifically for educational purposes (e.g., tuition, books, etc.), can be exempt. Count only that portion which is for personal use, (e.g., housing, food, utilities).

Note: Educational grants may be verified by viewing the grant document to determine its exempt or nonexempt status. The DPP Agreement must be documented to show how the grant was evaluated to determine its exempt or nonexempt status. Whenever possible, a copy of the grant document is to be attached to the DPP Agreement.

Education loans should not be considered income to the extent they are required to be repaid.

3. General Relief (GR) From Another County

An applicant participating in other County's General Relief Program (GR) must also complete an DPP Agreement.

There are three acceptable methods for verifying current eligible GR status:

a. The current month's MEDS clearing showing eligible status,

b. The GR Electronic Benefits Transaction (EBT) card with eligibility confirmed through Point of Service (POS) device, or

c. Telephone clarification with the recipient's eligibility worker.

G. Income Deductions

If family income is at or below 350% FPL, the patient is eligible for the DPP. There is no need to include income deductions. If the family income exceeds 350% FPL, allow income deductions for inpatient services only.

Certain income deductions and expenses paid by the applicant or responsible relative(s) are allowable. Verification of income deductions for the month the DPP Agreement is effective will be requested. If the applicant cannot provide acceptable verification, the amount cannot be allowed as a deduction.

1. Standard Work Expense

a. $90 work expense allowed for each employed person regardless of hours of employment.

b. Federal tax, State tax, FICA deductions are not allowed.

c. Transportation costs, cost of uniforms, etc. are not allowed.

2. Work-Related Expenses

Additional expenses that may be deducted from income in determining the DPP liability include child-care. Verification for work-related expenses should be obtained, whenever possible.

The cost of child-care is an allowable deduction provided both parents are employed. If only one parent is working, the cost of child-care may be allowed only if the second parent is unable to provide care (e.g., parent in home is incapacitated/disabled).

The monthly maximum childcare deduction that can be allowed is $175 for each child two years of age or older. For each child under two, the maximum allowed is $200.

Acceptable verification may include receipts, cancelled checks, or a statement from the child care provider. Documents used as verification are to be attached to the DPP Agreement.

3. Business Expenses for Self-Employed individuals

Verification of business expenses should be obtained. If the person is self-employed, the reasonable and necessary expenses which are incurred in the production of income (if allowed by the Federal Government for income tax purposes) are to be deducted from gross business profit to determine net profit. Net profit apportioned monthly is the amount of income to be shown on the DPP Agreement. (Business expenses may include salary, inventory costs, rent, etc.).

The Federal Income Tax return is the preferable type of verification. However, if the person was not self employed the previous year, or had not filed an income tax return, or last year's return does not accurately represent current expenses, current business records may be provided for the three months prior to the effective date of the DPP Agreement. If both the tax return and current records are unavailable, an affidavit detailing the allowable business expenses is acceptable.

Copies of documents verifying business expenses must be attached to the DPP Agreement.

4. Property Expenses Where Income Is Property Related

Verification of property expenses should be obtained, whenever possible. Allowable deductions from income generated by the rental of property may include the monthly interest on encumbrances and, apportioned on a monthly basis, property taxes, insurance, utilities, and upkeep/repairs.

The following are acceptable methods of verifying expenses associated with income from rental property:

a. The amount of interest would be the amount on payment records or an annual interest statement from the lender;

b. Property taxes may be taken from the official tax statement, and apportioned monthly;

c. The cost of insurance payments, including earthquake insurance, would be the amount indicated on the premium notices or a statement from the insurance company, and apportioned monthly;

d. Allow the estimated amount of the last three months of utilities paid by the applicant for this real property and divide total by 3 to determine the average monthly amount;

e. The actual cost of upkeep and repairs is based on the owner's records. Allow the actual amount for the last 6 months and divide total by 6 to determine the average monthly amount.

Photocopies of the documents used as verification are to be attached to the DPP Agreement.

5. Other Allowable Deductions from Income

Verification for other allowable deductions should be obtained.

a. Child/Spousal Support

Support payments must be court ordered to be allowed as a deduction. Voluntary support payments cannot be allowed. Deductions for actual, allowable payments made in support of a child or spouse not in the home are allowed. (In no instance shall the deduction allowed exceed the amount of the payment required by the court order.)

Payment records for the month the DPP Agreement is effective will be requested. If the applicant cannot provide a copy of the court order and payment record, the amount cannot be allowed as a deduction.

Photocopies of documents viewed should be attached to the DPP Agreement.

b. Medical Insurance Premiums

Premiums paid for medical insurance coverage, including Medicare Part A, Part B, and Part D, can be deducted. Allowable premiums must be converted to monthly amounts.

Medical insurance records for the month the DPP Agreement is effective will be requested. Acceptable verification of medical insurance premiums may include a paycheck stub, or an employer's statement when the premiums are deducted from earnings. If the premiums are paid directly to the insurance company by the person, a canceled check or receipt is acceptable verification. Medicare premiums may be verified by viewing a bill for Part A or Part B premiums, Form SSN 1545 or 1545A, or other correspondence from the Social Security Administration/Railroad Retirement Board.

Photocopies of the documents used to verify medical insurance premiums paid are to be attached to the DPP Plan Agreement.

H. Family Size

Family size is not a verifiable item; however, when the family includes a pregnant woman, documentation on the DPP Agreement is required to clarify whether the unborn is to be included in the Family Size number. For DPP purposes, verification of pregnancy is required; the unborn may be included beginning with the first month of verified pregnancy.

Family members who are receiving public assistance (i.e., SSI/SSP and CalWORKS) are excluded when determining family size, their income from such programs is not counted.

Acceptable verification of pregnancy includes:

1. MEDS or LRS printout, if the patient has pregnancy related Medi-Cal,

2. A written statement signed by a physician or a person certified as a nurse practitioner, nurse midwife or physician's assistant with access to the patient's medical records, confirming pregnancy,

3. Applicant's declaration of pregnancy, or

4. Viewing and documenting on the DPP Agreement the following information from the patient's hospital/clinic medical records:

    a. The date of the medical records entry confirming pregnancy,

    b. The expected date of delivery,

    c. The name of the physician, certified nurse practitioner, nurse midwife, or physician's assistant who diagnosed the pregnancy and signed the medical records entry,

    d. The location of the medical records, and

    e. The date the medical records were viewed.

I. Other Coverage

In the event that, during the term of the DPP Agreement the patient becomes eligible for other third party coverage, except Medi-Cal, such as private insurance, the DPP Agreement remains in place and shall be deemed applicable only to patient deductibles and coinsurance, and services that are outside of the scope of the third party coverage.

In the event that the patient becomes eligible for Medi-Cal without a share-of-cost (SOC), the DPP Agreement shall remain in place and shall be deemed applicable only to charges for services that are outside of the scope of Medi-Cal coverage.

In the event that the patient becomes eligible for Medi-Cal with SOC, the DPP Agreement shall remain in place, and shall apply to all services, whether in the Medi-Cal scope of coverage or not. The discount is applied to the gross charges, not the patient responsible amount.

J. Review Process

DPP applicants are to be informed that if they dispute their DPP eligibility or liability amount determinations, they may request a review at the supervisory level within 10 working days of the application decision.

AFFIDAVITS AS VERIFICATION

Affidavits are to be used with restraint. Facility policy, together with these verification guidelines, will determine when an affidavit, which contains all pertinent data, may be substituted as acceptable verification of information provided by a person who is cooperating fully in the application process. Before an affidavit is to be accepted as verification, the interviewer should initiate a request to the person/agency/organization for other evidence, as appropriate, for the item to be verified. A signed and completed authorization to release information (e.g., ABCDM 228) must accompany any such request.

The DPP Agreement is to be documented to show the reason why an affidavit is being used in lieu of other documents to verify required items and what attempts were made to secure more appropriate or preferred evidence.

Exhi.bit V

STATC Of C1-'.Jf0RIiil• HCALTHANO HIJi.l.c.N SEl'!VI('.J:.!;AGI!NCV C>\I.IJ'ORNI.OEAARTMFJ:T OF SOCIAI OF.fWJC.ES

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

!AGE!CVOR INDIVIDLIAJ.. FROM WHOM 1nFOfiIM':'!CN IS REQUESTED\

To:

\. - R;SID!rG AT

'HEREBY AUTHORiZEYOU TO RELEASE TO TKE

(NAME OF AGENCY, INSTITUTION, INDIVIDUAL PROVIDER) SPECIFIC

lllFORMAlION REQUESl'lm ilY THIS AGENCY WHICH I CAWOT PROViOE CONCCRNING

THIS JNFORMF.TION IS t:EEDED FOR THE FOLLOWING PURPOSE

THIS FORM WAS. COM?LE:IF..D IN IT:i ENT1RETY /\ND WIS READ OY ME tOR RF.AU TO ME) f'RJf.li-\ 10 SIGNING

SIGNATURE OF APPLICANT DATE

BIRTHPLACE BIRTHDATE MAIDEN !AME OF JJ.6fHr.ft·

SIGNATURE OR NAME OF SPOUSE

BIRTHPLACE OF SPOUSE BIRTHDATE OF SPOUSE MAICEH Mt.ME OF Si'OIJJ('11!IOTHCR

L

ASCDM 228 (ENG/SP) (6/89)